SOMNIQUE
HEALTH

Hello,

I would like to be the first to welcome you to Somnique Health. It is my pleasure to introduce you to our team. My name is Vivek Dogra, MD. I am the Medical Director here at our facility. I will see you in consultation and follow-up and also interpret your sleep study. I will spend time with you to discuss any issues you are having with your sleep and we will come up with a long term, positive resolution for you.

I would also like to tell you about our Clinical Manager, Joedi Robinson. She is completely devoted to helping each and every client, so please feel free to call her as she is always available to answer any clinical questions you may have. I am here to assist you with any questions or concerns you may have during your time with us as well.

You have probably scheduled your appointment with one of our medical receptionists, Lydia or Giselle. They are also available to answer any questions you may have. They are dedicated to making sure each client is greeted with a warm welcome, and that all of your needs are met.

At Somnique Health we pride ourselves on doing our absolute best to make sure each and every client has a pleasant experience. Your well-being is our #1 priority and that is echoed every step of the way. If you feel as though you have not received superior care from the beginning of your experience with Somnique Health, please do not hesitate to contact either Joedi or I. It is very important to all of us that you are taken care of. Again, thank you so much for choosing to work with us.

Please call us with any questions.

Sincerely,

Vivek Dogra, M.D.
Medical Director
Somnique Health
(503)688-5536

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***Late cancellations and no-show appointments may be charged a $50 fee**

Pediatric Sleep Questionnaire

Date: _____

Name _____

D.O.B. _____/_____/_____ Age _____ Sex _____ Height _____ Weight _____

HISTORY

Briefly describe the problem your child is having with his or her sleep.

_____

_____

_____

Please check if your child currently has or has had any of the following:

_____ Snores loudly.

_____ Snores in all positions.

_____ Stops breathing at night.

_____ Wakes up gasping for breath.

_____ Wakes up coughing or choking.

_____ Frequent nightmares.

_____ Wakes up screaming.

_____ Behavioral issues.

_____ Hyperactive.

_____ Poor grades in school.

_____ Currently takes naps during the day.

_____ Feels sudden physical weakness during strong emotions (such as mouth dropping open or legs going limp during laughter or anger.)

_____ Excessively sleepy during the day.

_____ Excessive daytime fatigue.

_____ Sudden episodes of sleep during the day.

_____ Sleep walking.

_____ Bedwetting.

_____ Difficulty concentrating.

_____ Wakes up with a sour taste in their mouth.

_____ Sleep talk.

_____ Sleep walk.

_____ Restless sleep.

_____ Kicks or thrashes around at night.

_____ Difficulty maintaining sleep at night.

_____ Frequent awakenings.

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SLEEP SCHEDULE

	Weekday:	Weekend:
What time does your child go to bed?	_____ AM/PM	_____ AM/PM
What time does your child wake up?	_____ AM/PM	_____ AM/PM
Average amount of sleep per night	_____ hours	_____ hours

Does your child share a bedroom with other siblings? _____ Yes _____ No
Does your child have a TV in the bedroom? _____ Yes _____ No

Allergies_____

SYSTEMS REVIEW

Please check if your child currently has or has had any of the following:

Constitutional
_____ Fever _____ Weight gain _____ Weight loss _____ Fatigue _____ Night sweats

Eyes
_____ Pain _____ Redness _____ Loss of vision _____ Double or blurred vision _____ Dryness

Ears-Nose-Mouth-Throat
_____ Hearing loss _____ Nosebleeds _____ Loss of smell _____ Dryness in nose _____ Loss of taste
_____ Sores in mouth _____ Dryness of mouth _____ Hoarseness

Cardiovascular
_____ Chest Pain _____ Irregular heart beat _____ High blood pressure _____ Swollen legs or feet

Respiratory
_____ Shortness of Breath _____ Difficulty breathing at night _____ Cough _____ Coughing up blood
_____ Wheezing

Gastrointestinal
_____Loss of appetite _____Nausea _____Vomiting of blood or "coffee ground' material
_____ Abdominal pain _____ Heartburn/reflux _____ Difficulty swallowing _____ Diarrhea
_____ Constipation _____ Blood in stools _____ Black stool

Urinary
_____ Difficult urination _____ Pain or burning on urination _____ Blood in urine
_____Discharge from penis/vagina _____Rash/ulcers

Musculoskeletal
_____ Morning stiffness _____ Joint pain or swelling _____ Muscle weakness _____ Muscle tenderness

Skin
_____Easy bruising _____Rashes _____Sun sensitivity _____Tightness _____Nodules/bumps
_____ Hair loss

Neurological
_____ Headaches _____ Dizziness _____ Weakness _____ Memory loss

Psychiatric
_____ Excessive worries _____ Anxiety _____ Easily loses temper _____ Depression _____ Agitation

Endocrine:
_____ Excessive thirst

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Hematologic:
_____Swollen glands _____Tender glands _____Bleeding tendency _____Anemia _____Transfusions

SOCIAL HISTORY

Please check and answer all of the following:

Does your child drink coffee, tea, or soft drinks? _____Yes _____ No
If yes, regular _____ or decaffeinated _____ How much daily? _____

How many meals does your child eat daily? 0 1 2 3 4 5

Does your child exercise regularly? _____Yes _____ No
If yes, what time of the day? _____ Morning _____ Mid-day _____ Evening

PAST MEDICAL HISTORY

Has your child had any surgeries? If yes, what year?
_____ Appendectomy _____ _____ Ear nose or throat surgery_____
_____ Other _____
Hospitalizations: _____
Does your child have any history of the following medical problems? If yes, please mark.
_____ Heart disease _____ Lung disease _____ Diabetes _____ Seizure disorder
_____ Other (please explain)_____
Allergies: _____

CURRENT MEDICATIONS

Medication list (Please list the name of each medication.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Over the counter medications / herbal supplements

_____

IMMEDIATE FAMILY (mother, father, siblings)

Person with disorder
Diabetes _____
Heart disease _____
High blood pressure _____
Stroke _____
Obesity _____

Person with disorder
Snoring _____
Sleep Apnea _____
Narcolepsy _____
Daytime sleepiness _____
Other _____

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HEALTH

Please add any other information you would like us to know that is not covered in this questionnaire.

_____

_____

How did you choose Somnique Health? Check and explain all that apply.

_____ Physician _____

_____ On-line _____

_____ Friend _____

_____ Newspaper _____

_____ Radio _____

_____ Other _____

Thank you for your time in filling this questionnaire out. It is a valuable tool for the physician.

Please bring this with you to your first appointment. We look forward to meeting you and your child!

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Patient Name:_____
(Print name and sign below)

DISCLOSURE AND AUTHORIZATION

Patient Consent

I am requesting that Somnique Health and the doctors who practice there will test me for possible sleep disorders. I understand that as a patient, I am required to authorize Somnique Health for such services. I am hereby authorizing such tests. I understand that photos, digital video, and other images may be recorded to document my care, and I consent to this. I understand that Somnique Health will retain the ownership rights to the photos, digital video, and other images but that I will be allowed to view them and obtain copies upon my request. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for a time period that is required by law. I have consulted my physician and I understand the tests that I will undergo. By signing this consent, I authorize the Somnique Health staff to perform the tests that are ordered by the physician.

Receipt of Notice of Privacy Practices and Disclosure, Patient Rights and Responsibility, and Provider Performance Standards

I have reviewed and understand the Privacy Practices, Patient Rights and Responsibility, and Provider Performance Standards. I understand my rights as they are contained in these documents. I authorize the use and disclosure of my health information for the purposes of treatment, determination of benefits, payment, and care as described in the Privacy Practices. This includes any doctors and their staff who provide services for Somnique Health, durable medical equipment company and their staff which will provide me with medical equipment. I authorize Somnique Health to leave voicemails on the phone numbers I have provided to them, and with whoever may answer at those phone numbers. This may include messages that are left at my business.

Patient Assignment of Benefit Agreement

I understand that the explanation of benefit from my insurance carrier is not a bill from Somnique Health. I understand that no charges are due from me until I receive a statement from Somnique Health. I understand that if I have billing questions, I can call Somnique Health to provide me with these answers and that they may seek assistance from eCW (their electronic medical records and billing company).

I understand that ultimately, I bear the responsibility for the payment of all fees associated with the procedures provided by Somnique Health. I am responsible for all charges not covered by my insurance carrier and if I receive any payments from my insurance carrier directly, I will immediately forward such payment to Somnique Health for the services they provided. Services provided may include tele-medicine visits.

I authorize direct remittance of payment of all insurance or Medicare benefits to Somnique Health for all covered services. I understand and agree that this assignment of benefits will have continuing effect for so long as I am being cared for by Somnique Health. I authorize my insurance company to mail all payments directly to Somnique Health.

Commercial Drivers

I understand if I am diagnosed with a sleep disorder, the Department of Motor Vehicles may be contacted if I do not follow my doctor's instructions and recommendations, or if I am found to be non-compliant with my treatment.

Past Due Accounts

I understand that a fee may be charged on all accounts which are 90 days or more past due at a rate of 1% per month. I understand that the 1% may be added to the account and hereby agree to pay such charges if levied. I also understand that if my account is placed with a collection agency, additional fees with ensue including court costs and those fees will be added to my account balance.

Check Acceptance Policy

Checks that are returned to Somnique Health unpaid from your account will be assessed an additional **$25 NSF fee**. Returned balance plus additional fee will be required to paid off in the form of cash or credit card. We accept Visa, Mastercard, American Express and Discover.

Cancellation Policy

I understand that I must provide at least a 24-hour notice to any appointments I am unable to keep. If I do not provide at least a 24-hour notice prior to a cancellation or if I do not show up for a scheduled appointment I understand that I will be charged a cancellation fee of $50.00 for clinic visits and $200.00 for sleep studies.

I have read and understand all of the above, and my initials and signature represent acceptance and acknowledgement for all of the above. I authorize a copy of this form to be used in place of the original.

_____ _____

SIGNATURE DATE

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Demographic Form

PATIENT INFORMATION **DATE:**_____

Name of Patient: _____ DOB ____/____/____ Male_____ Female_____

Home Address: _____ City_____ State_____ Zip_____

Choose One: Single_____ Married_____ Divorced_____ Separated_____ Widowed_____

Race: _____ Language: _____

Primary Telephone: ( ) _____ Secondary Telephone: ( ) _____

Social Security #: _____

Email Address: _____

Employer: _____ Business Phone: ( ) _____

Employer's Address: _____

*Emergency Contact Name: _____

Emergency Contact Relationship: _____ *Emergency Contact Telephone: ( ) _____

Primary Care Physician: _____ Phone: ( ) _____

Pharmacy Name: _____ Location: _____

Pharmacy Phone: ( ) _____

Insurance Company: _____ ID#: _____

Group#: _____ Subscriber: _____

GUARDIAN INFORMATION (if patient is a minor)

Name: _____ Relationship: _____

Phone: ( ) _____ Date of Birth: ____/____/____ Social Security #: _____

Do you reside at the same address? Y N if no, what is your address? _____

Employer: _____ Employer's Address: _____

Business Phone: ( ) _____ Email Address: _____

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SLEEP HEALTH

Patient Name: _____

Date: _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

Use the following scale to choose the most appropriate number for each situation.

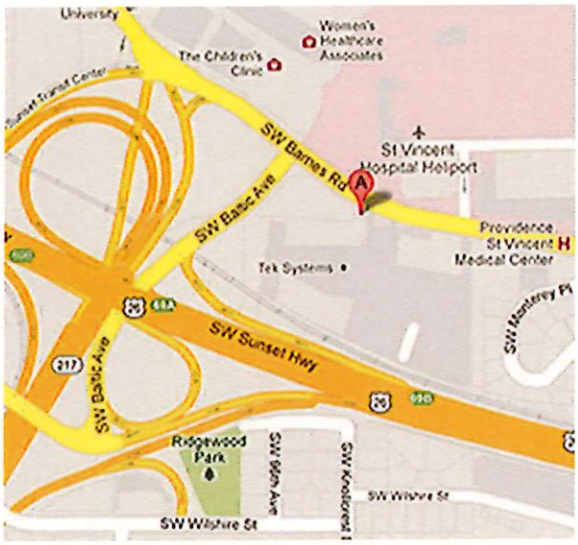
0–Would never doze 1—Slight chance of dozing
2—Moderate chance of dozing 3—High chance of dozing

SITUATION	CHANCE OF DOZING (0–3)
Sitting and reading	_____
Watching television	_____
Sitting, inactive in a public place such as a theater or a meeting	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

TOTAL SCORE add all responses _____

Somnique Health

9450 SW Barnes Road Suite 140 Portland, OR 97225
Phone: 503-688-5536



Directions

From I-5 North

1. Merge onto I-5 South
2. Take exit 302B for Interstate 405/US 30W. Continue to follow I-405 South.
3. Take exit 1D to merge onto US-26 W toward Beaverton
4. Take exit 69B toward Park Way / Barnes Road
5. Keep right at the fork, follow signs for Barnes Road and merge onto SW Baltic Ave
6. Turn right onto SW Barnes Road
7. Take the first right into the drive and another immediate right into the parking lot to end at 9450

From I-5 South

1. Merge onto I-5 North
2. Take Exit 292A to merge onto OR-217 N toward Tigard/ Sunset Hwy/ Oregon Coast
3. Take the Barnes Road exit
4. Keep right at the fork, follow signs for Barnes Road E and merge onto SW Barnes Road
5. Take the first right into the drive and another immediate right into the parking lot to end at 9450

From Highway 26 East

1. Merge onto US-26 W
2. Take exit 69B toward Park Way / Barnes Road
3. Keep right at the fork, follow signs for Barnes Road and merge onto SW Baltic Ave
4. Turn right onto SW Barnes Road
5. Take the first right into the drive and another immediate right into the parking lot to end at 9450

From Highway 26 West

1. Merge onto US-26 E
2. Take exit 69B toward Park Way / Barnes Road
3. Keep right at the fork, follow signs for Barnes Road and merge onto SW Baltic Ave
4. Turn right onto SW Barnes Road
5. Take the first right into the drive and another immediate right into the parking lot to end at 9450

From OR-217 South

1. Merge onto OR-217 North
2. Take the Barnes Road exit
3. Keep right at the fork, follow signs for Barnes Road and merge onto SW Baltic Ave
4. Turn right onto SW Barnes Road
5. Take the first right into the drive and another immediate right into the parking lot to end at 9450

From OR-217 North

1. Merge onto OR-217 South
2. Take the Barnes Road exit
3. Keep right at the fork, follow signs for Barnes Road and merge onto SW Baltic Ave
4. Turn right onto SW Barnes Road
5. Take the first right into the drive and another immediate right into the parking lot to end at 9450

Trimet Passengers:

Bus 20 stops near our location and Sunset Transit Center is less than a mile away

SOMNIQUE
SLEEP HEALTH

Health Information Release Authorization

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Choose one:

_____ I authorize Somnique Sleep Health to release medical records information to:
_____ I authorize Somnique Sleep Health to obtain medical records information from:

Clinic/Doctor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

The purpose of this request is to:

_____ Continuity of care _____ Attorney _____ Personal use _____ Insurance
_____ Other *I understand that I am entitled to one free copy of my medical records.*
Any additional copies requested are subject to a fee of $1 per page.

Information Needed:

_____ Last Chart Note only _____ Chart notes from Date: _____ to Date: _____
_____ Sleep Study results _____ Last Compliance Report _____ Other

Authorization:

I understand that the information in my health record may contain information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also contain information about behaviors or mental health services and treatment for alcohol and or drug abuse. This authorization is effective for the duration of my treatment unless revoked or terminated by the patient's personal representative. It is understood that my records may not be released to me at the same time as requested. It can take 24 hours to 30 days from the time of my request. I understand that I may revoke or terminate this request by contracting Somnique Health. I understand that revocation will not apply to information that has previously been released in response to this authorization. Information that is disclosed in this authorization may be disclosed again to the organization or person which it is sent. The privacy of this information is in compliance with the Health Insurance Privacy and Portability Act of 1996.

_____ _____
SIGNATURE DATE

Vivek Dogra, MD Medical Director
9450 SW Barnes Road, Ste. 140 Portland, OR 97225 503.688.5536 1.855.976.6642 (toll free) f 503.688.5509
www.Somnique.com

SOMNIQUE HEALTH

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you may gain access to this information. Please review it carefully. Somnique Health is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected information.

Disclosure of your health care information:

*Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

*Payment: We may disclose your health care information to your insurance provider for the purpose of payment or healthcare operations. If payment is not made as arranged, our office may utilize an outside collection agency or other means of collecting an outstanding debt. Your file containing protected health care information may be reviewed by the designated collection agency or authority.

*Workers compensation: If applicable we may disclose your health care information as necessary to comply with the Workers Compensation Laws.

*Public Health: As required by law, we may disclose your health care information to public health authorities for purposes related to: preventing or controlling a disease, injury, disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products or reactions to medication, and reporting disease or infection exposure.

*Emergencies: We may disclose your health care information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in an emergency or of your death.

*Judicial and Administrative Proceedings: We may disclose your health care information in the course of any judicial or administrative proceeding.

*Public Safety: It may be necessary to disclose your health care information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

*Law Enforcement: We may disclose your health care information to a law enforcement official for purposes such as locating or identifying a suspect, fugitive, material witness, or missing person, complying with a court ordered subpoena, and any law enforcement purposes.

*Deceased Persons: We may disclose your health care information to a coroner or medical examiner.

*Organ Donation and Research: We may disclose your health care information to organizations involved in procuring, banking, or transporting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

*Specialized Government Agencies: We may disclose your health care information for military, national security, prisoner, and government benefits purposes.

*Change of Ownership: In the event that Somnique Health is sold or merged with another organization, your health care information will become the property of the new owner.

Your Health Information Rights:

*You have the right to request restrictions on certain uses and disclosures of your health care information. Please be advised however, that Somnique Health is not required to agree to the restriction you requested.

*You have the right to have your health care information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery upon your request.

*You have the right to inspect or copy your health care information.

*You have the right to request that Somnique Health amend your protected health care information. Please be advised however, that Somnique Health is not required to agree to amend your protected health care information. If your request has been denied, you will be provided with an explanation of our denial and information on how you can disagree with the denial.

*You have the right to receive an accounting of disclosures of your protected health care information made by Somnique Health.

*You have the right to a paper copy of this Notice of Privacy Practices at the time of your request.

Changes to this Notice of Privacy Practice:

Somnique Health reserves the right to amend this Notice of Privacy Practice at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Somnique Health is required to comply with this notice. Somnique Health is required by law to maintain the privacy of your health care information and to provide you with notice of its legal duties and privacy practices with respect to your health care information. If you have any questions about this part of the notice, or if you want more information about your privacy rights, please contact us at (503) 688-5536. If no one is available you may leave a message and your call will be returned within 2 business days.

Complaints

Complaints about your privacy rights or how Somnique Health has handled your health care information should be directed to Somnique Health at (503) 688-5536. If no one is available you may leave a message and your call will be returned within 2 business days. If you are not satisfied with the manner in which your complaint was handled, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Ave SW, Room 509F, HHH Building, Washington, DC 20201.

SOMNIQUE
HEALTH

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient of Somnique Health you have the right:

*To be treated with dignity and compassion and to have your privacy and property to be respected at all times.
*To privacy and confidentiality of all records pertaining to your care, except as otherwise provided by law, and to have access to those records upon request.
*To receive appropriate care and services in a professional manner without discrimination relative to your age, race, sex, religion, ethnic origin, sexual preference, physical or mental handicap, or personal, cultural, and ethnic preferences and to be free from any mental abuse, physical abuse, neglect, or exploitation of any kind by our staff.
*To obtain complete and clear information concerning your diagnosis, your treatment, and your prognosis.
*To exercise your rights as a patient, such as providing informed consent, or to have your authorized representative exercise your rights as a patient.
*To participate in the development and modification of your care and service plan and to refuse treatment within the boundaries set by law.
*To be informed of the services which are available at our facility, who will be providing care, and the fees and charges for such services and products provided.
*To be informed of any experimental treatment or research study and to refuse to participate in these projects.
*To express concerns, grievances, or recommendations without fear of discrimination or reprisal and to be involved as appropriate in discussions and resolutions of conflict and or ethical issues related to your care. Please report all concerns of grievances to the Clinical Administrator, Erica Cayson at (503) 688-5536.

You have the responsibility:

*To keep scheduled appointments, and when unable to do so, notify us immediately.
*To be considerate of other patients and staff and to control noise and other distractions while at our facility.
*To respect the privacy and property of others and the facility.
*To notify your caregivers when you feel ill or if you encounter any unusual physical or mental stress while at our facility.
*To provide complete and accurate information concerning your present health, medications, allergies, etc. when appropriate to your care and service.
*To notify us of any changes to your health insurance coverage, changes in your address or contact information, or changes in your medical history.
*To request additional assistance or information on any phase of your health care plan that you do not fully understand.
*To actively participate in decisions about your health care and to comply with treatment recommendations.
*To promptly fulfill financial obligations to the facility by making payments when they are due, or by providing documentation or information in order to complete insurance claim filing.